BILL ANALYSIS

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By: Kolkhorst
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The 83rd Texas Legislature approved the expansion of Medicaid managed care and the transition from fee for service based payment to quality incentive and performance based payments. Nearly 95 percent of Medicaid recipients currently receive their benefits through managed care.

The Health and Human Services Commission also administers Medicaid waiver programs to provide Medicaid benefits and services to individuals outside of an institutional setting.

S.B. 2028 seeks to improve the Medicaid managed care program in a variety of ways as well as improve the management of the Medicaid waiver interest list for those waiting to receive Medicaid benefits and services.

As proposed, S.B. 2028 amends current law relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Health and Human Services Commission in SECTION 1 (Sections 531.024142 and 531.02493, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.024142, 531.02493, 531.0501, 531.0502, 531.0512, and 531.0605, as follows:

Sec. 531.024142. NONHOSPITAL AMBULANCE TRANSPORT AND TREATMENT PROGRAM. (a) Requires the Health and Human Services Commission (HHSC) by rule to develop and implement a program designed to improve quality of care and lower costs in Medicaid by:

(1) reducing avoidable transports to hospital emergency departments and unnecessary hospitalizations;

(2) encouraging transports to alternative care settings for appropriate care; and

(3) providing greater flexibility to ambulance care providers to address the emergency health care needs of Medicaid recipients following a 9-1-1 emergency services call.

(b) Requires that the program be substantially similar to the Centers for Medicare and Medicaid Services' Emergency Triage, Treat, and Transport (ET3) model.

Sec. 531.02493. CERTIFIED NURSE AIDE PROGRAMS. (a) Requires HHSC by rule to establish and implement a program to provide certified nurse aides trained in the Grand-Aide curriculum or a substantially similar training program to provide in-home support to a Medicaid recipient's care team after the recipient's discharge from a hospital. Requires that the program allow a Medicaid managed care organization to treat payments

to certified nurse aides providing care under the program as quality payments for purposes of meeting contract percentage requirements.

(b) Authorizes HHSC by rule, subject to Subsection (c), to establish and implement a program under which the parent of a child with complex medical needs may receive Medicaid reimbursement if the parent receives training and is certified as a nurse aide and provides care for the child.

(c) Authorizes HHSC to establish the program described by Subsection (b) only if HHSC determines that the program will reduce Medicaid costs and improve the quality of care for Medicaid recipients who are children with complex medical needs.

Sec. 531.0501. MEDICAID WAIVER PROGRAMS: INTEREST LIST MANAGEMENT. (a) Requires HHSC to establish an online portal for use by individuals seeking Medicaid waiver program services to request to be placed on a Medicaid waiver program interest list. Requires that the portal:

(1) provide the current interest list questionnaire information for each Medicaid waiver program;

(2) allow real-time access to an individual's interest list status; and

(3) result in information that will inform the priority for an individual's placement on the most appropriate interest list.

(b) Authorizes HHSC to remove an individual from a Medicaid waiver program interest list if the individual has not had any communication with HHSC for at least five years. Requires HHSC, after removing the individual from the interest list, to maintain a record of the individual's name and any other information HHSC has concerning the individual and the individual's initial interest list request date.

Sec. 531.0502. MEDICAID WAIVER PROGRAMS: ENROLLMENT AND STRATEGIC PLAN. (a) Requires HHSC, beginning not later than September 1, 2023, to prioritize enrollment in Medicaid waiver programs based on a Medicaid recipient's level of need for services under a program.

(b) Requires HHSC to develop a strategic plan to identify:

(1) the most effective methods for assessing the needs of Medicaid recipients on Medicaid waiver program interest lists and for matching a recipient with the program that best meets the recipient's level of need; and

(2) based on a needs assessment, a method for prioritizing Medicaid recipients on Medicaid waiver program interest lists and assigning those recipients who have been on an interest list for five years or more a position on the list.

Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION MODEL. Requires HHSC to:

(1) develop a procedure to verify that a Medicaid recipient or the recipient's parent or legal guardian is informed regarding the consumer-direction model and provided the option to choose to receive care under that model, and if the individual declines to receive care under the consumer-directed model, document the declination; and

(2) ensure that each Medicaid managed care organization implements the procedure.

Sec. 531.0605. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM. (a) Requires HHSC to collaborate with Medicaid managed care organizations to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions.

(b) Requires HHSC to seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and actively seek and apply for federal funding to implement the program.

(c) Requires HHSC, not later than December 31, 2024, to prepare and submit a report to the legislature that includes:

(1) a summary of HHSC's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions; and

(2) a recommendation as to whether the pilot program should be continued, expanded, or terminated.

(d) Provides that the pilot program terminates and this section expires September 1, 2025.

SECTION 2. Amends Section 533.0025, Government Code, by adding Subsections (j) and (k), as follows:

(j) Requires HHSC to implement the most cost-effective option for the delivery of basic attendant and habilitation services and services under the community attendant services program for recipients under the STAR Medicaid managed care program.

(k) Requires HHSC to determine and implement the most cost-effective option for the delivery of hospice services for recipients under the STAR+PLUS Medicaid managed care program.

SECTION 3. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.00515 and 533.0069, as follows:

Sec. 533.00515. MEDICATION THERAPY MANAGEMENT. Requires the executive commissioner of HHSC (executive commissioner) to collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

Sec. 533.0069. COORDINATION OF SCHOOL HEALTH AND RELATED SERVICES. (a) Requires HHSC, in coordination with Medicaid managed care organizations and the Texas Education Agency, to develop and adopt a policy for the Medicaid managed care program to ensure the coordination and delivery of benefits and services provided under the school health and related services program, including coordination of school health and related services with early childhood intervention services.

(b) Requires HHSC, not later than December 31, 2024, to prepare and submit a report to the legislature that includes a summary of HHSC's efforts regarding coordinating school health and related services and early childhood intervention services.

SECTION 4. Amends Section 533.0076, Government Code, by amending Subsection (c) and adding Subsection (d), as follows:

(c) Deletes existing text requiring HHSC to allow a recipient who is enrolled in a managed care plan under Chapter 533 (Medicaid Managed Care Program) to disenroll from that plan and enroll in another managed care plan once for any reason after the periods described by Subsections (a) (relating to prohibiting a recipient enrolled in a managed care plan from disenrolling from that plan and enrolling in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan) and (b) (relating to authorizing the recipient, at any time before the 91st day after the date of a recipient's initial enrollment in a managed care plan, to disenroll from that plan for any reason and enroll in another managed care plan). Makes nonsubstantive changes.

(d) Requires HHSC to ensure that each recipient receives information regarding the recipient's option under Subsection (c).

SECTION 5. Amends Section 533.009(c), Government Code, as follows:

(c) Requires that the managed care organization, at a minimum, be required to:

(1) and (2) makes nonsubstantive changes to these subdivisions; and

(3) if a disease management program provided by the organization has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients.

SECTION 6. Amends Section 32.028, Human Resources Code, by adding Subsection (p), to require the executive commissioner to establish a reimbursement rate for medication therapy management services.

SECTION 7. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Sections 32.0611 and 32.0612, as follows:

Sec. 32.0611. COMMUNITY ATTENDANT SERVICES PROGRAM: HIRING PROCESS. Requires HHSC to require an entity with which HHSC contracts to provide personal attendant services to recipients under the community attendant services program to streamline the application and hiring process for prospective attendants, including requiring the entity to consolidate any required application documents and forms.

Sec. 36.0612. COMMUNITY ATTENDANT SERVICES PROGRAM: QUALITY INITIATIVES AND EDUCATION INCENTIVES. (a) Requires HHSC to develop specific quality initiatives for attendants providing services under the community attendant services program to improve quality outcomes for program recipients.

(b) Requires HHSC to coordinate with the Texas Higher Education Coordinating Board and the Texas Workforce Commission to develop a program to facilitate the award of academic or workforce education credit for programs of study or courses of instruction leading to a degree, certificate, or credential in a health-related field based on an attendant's work experience under the community attendant services program.

SECTION 8. (a) Defines "commission," "executive commissioner," and "Medicaid."

(b) Requires HHSC, using existing resources, to:

(1) review HHSC's staff rate enhancement programs to identify and evaluate methods for improving administration of those programs to reduce administrative barriers that prevent an increase in direct care staffing and direct care wages and

benefits in nursing homes and develop recommendations for increasing participation in the programs;

(2) revise HHSC's policies regarding the quality incentive payment program (QIPP) to require improvements to staff-to-patient ratios in nursing facilities participating in the program and to set a goal for those nursing facilities to meet all Centers for Medicare and Medicaid Services five-star quality rating metrics by September 1, 2027;

(3) examine, in collaboration with the Department of Family and Protective Services, the Centers for Medicare and Medicaid Services' Integrated Care for Kids (InCK) Model to determine whether implementing the model could benefit children in this state, including children enrolled in the STAR Health Medicaid managed care program;

(4) develop options for value-based arrangements with nursing facilities that consider facility hospitalization rates, infection control measures, and the number of citations for abuse or neglect the facility has received; and

(5) identify factors influencing active participation by Medicaid recipients in disease management programs by examining variations in eligibility criteria for the programs, and participation rates by health plan, disease management program, and year.

(c) Authorizes the executive commissioner to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model.

SECTION 9. (a) Defines "commission" and "Medicaid."

(b) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to determine the cost-effectiveness and feasibility of providing to Medicaid recipients who have been diagnosed with diabetes, including Type 1 diabetes, Type 2 diabetes, and gestational diabetes:

(1) diabetes self-management education and support services that follow the National Standards for Diabetes Self-Management Education and Support and that are authorized to be delivered by a certified diabetes educator; and

(2) medical nutrition therapy services.

(c) Requires HHSC, if HHSC determines that providing one or both of the types of services described by Subsection (b) of this section would improve health outcomes for Medicaid recipients and lower Medicaid costs, notwithstanding Section 32.057 (Contracts for Disease Management Programs), Human Resources Code, or Section 533.009 (Special Disease Management), Government Code, and to the extent allowed by federal law to develop a program to provide the benefits and seek prior approval from the Legislative Budget Board (LBB) before implementing the program.

SECTION 10. (a) Defines "commission," "Medicaid," and "Medicaid managed care organization."

(b) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to determine the cost-effectiveness and feasibility of requiring that a Medicaid managed care organization provide early childhood intervention case management services to Medicaid recipients who receive services under the school health and related services program.

(c) Requires HHSC, not later than December 31, 2024, to prepare and submit a report to the legislature that includes a summary of HHSC's evaluation of the feasibility and

cost-effectiveness of providing early childhood intervention case management as a Medicaid managed care benefit and a recommendation as to whether HHSC should implement that benefit.

SECTION 11. (a) Defines "commission" and "Medicaid."

(b) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to determine the cost-effectiveness and feasibility of providing services under the Community First Choice program to Medicaid recipients transitioning from care in an institutional setting to care in a community-based setting.

(c) Requires HHSC, if HHSC determines that providing the types of services described by Subsection (b) of this section would improve health outcomes for Medicaid recipients and lower Medicaid costs, to the extent allowed by federal law to develop a program to provide the services and seek prior approval from LBB before implementing the program.

SECTION 12. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes delay of implementation until such a waiver or authorization is granted.

SECTION 13. Effective date: September 1, 2021.